STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225644	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Rehab Center	7 Loring Hills Avenue Salem, MA 01970

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on observation, record review and interview, the facility failed to ensure three Residents (#39, #25 and #38) received care in accordance with professional standards of practice, out of a total sample of 23 residents. Specifically, 1. For Resident #39, the facility failed to ensure a physician's order was developed for the use of a hand orthotic before it was in use. 2. For Resident #25, the facility failed to ensure a wound physician recommendation was implemented. 3. For Resident #38, the facility failed to implement physician's orders for daily dressing changes to the left elbow. Findings include: 1. Resident #39 was admitted to the facility in August 2023 with diagnoses including encephalopathy and Parkinson's Disease. Review of Resident #39's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated that the Resident had a Brief Interview for Mental Status score of 14 out of 15 indicating intact cognition. During an observation on 4/15/25 at 8:40 A.M., Resident #39 was awake in bed eating his/her breakfast. On the Resident's bedside table was a hand carrot orthotic device (a hand-held orthotic that positions the fingers away from the palm in the shape of a carrot) that was not being used. Resident #39 said staff do not check in with him/her on using the hand orthotic. During an interview on 4/15/25 at 11:09 A.M., Resident #39 said he/she would like to see physical therapy for his/her hands and using his/her hand orthotic. The Resident continued to say that staff do not check in about using the hand orthotic. During an observation on 4/15/25 at 1:58 P.M., Resident #39 was sleeping in bed, no hand orthotic was observed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #39's current and discontinued physician's orders failed to indicate the use of a hand carrot orthotic. Review of Resident #39's active care plans failed to indicate the use of a hand carrot orthotic. Review of Resident #39's Occupational Therapy Discharge Summary dated from 11/7/24 through 2/12/25 failed to indicate the recommendation or use of any hand orthotic. Review of Resident #39's Medication and Treatment Administration Records for April 2025 failed to indicate the use of a hand orthotic. During an interview on 4/16/25 at 11:44 A.M., the Director of Rehab (DOR) said Resident #39 has some weakness in his/her hands. The DOR continued to say he just provided the Resident a hand carrot orthotic to ease his/her anxiety and he/she was never evaluated for it. The DOR said a physician's order should be developed for the use of a hand orthotic. During an interview on 4/16/25 at 1:43 P.M., Nurse #5 said Resident #39 is dependent on staff for all care and the Resident has a hard time moving his/her hands. Nurse #5 said she has no knowledge of Resident #38 using a hand carrot orthotic. During an interview on 4/16/25 at 1:49 P.M., Nursing Supervisor #1 said Resident #39 is dependent on staff for most activities of daily living. Nursing Supervisor #1 said she was not aware of Resident #39 having a hand carrot orthotic, she continued to say there should be a physician's order for it so staff know how to monitor its use. 46339 2. Resident #25 was admitted to the facility in June 2018 with diagnoses including dementia and adult failure to thrive. Review of Resident #25's Minimum Data Set (MDS) Assessment, dated 3/15/25, indicated the Resident scored a 4 out of a total possible 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The MDS further indicated that the Resident had skin impairment. On 4/15/25 at 8:00 A.M., the surveyor observed Resident #25 lying in bed wearing prevalon boots on his/her feet. On 4/16/25 at 7:04 A.M., the surveyor observed Resident #25 lying in bed wearing prevalon boots on his/her feet. Review of the medical record indicated the following: -Physician order dated 2/27/25: Prevalon boots while in bed as tolerated/accepted every shift. -Physician order dated 4/3/25: Cleanse 2nd digit on right foot with normal saline, pat dry, apply betadine twice a day, leave open to air. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of wound physician recommendations dated 3/5/25, 3/12/25, 3/19/25, 3/26/25, 4/2/25 and 4/9/25 in the electronic medical record indicated the following: -Bed cradle to keep weight of blankets off toes. Review of the medical record failed to indicate the wound physician's recommendations had been addressed. Review of Resident #25's care plan indicated the following: -Focus: The Resident has actual impairment to skin integrity related to abrasion top of 2nd and 3rd digits on right foot upon return from hospital. -Intervention: Keep the pressure off Resident's feet. During an interview on 4/16/25 at 10:04 A.M., Unit Manager #1 said they were using prevalon boots as a substitute for a bed cradle. During an interview on 4/16/25 at 10:05 A.M., Wound Physician #1 said the Resident requires a foot cradle, he said he had indicated this in the recommendations that he writes to the facility multiple times and that the prevalon boots are not a substitute for the bed cradle. During an interview on 4/16/25 at 11:11 A.M., the Director of Nursing said the bed cradle should be in place if it was recommended by the Wound Physician. She then returned with a physician wound recommendation dated 3/19/25 indicating the following (not appropriate as patient will not keep feet in cradle) and said the nurse practitioner said no to the bed cradle. During an interview on 4/16/25 at 1:40 P.M., Nurse Practitioner #1 said she declined the recommendation as she did not think the Resident would be able to keep his/her feet in the bed cradle. When asked if the facility had attempted to provide the bed cradle and if the Resident was unable to keep feet in it, she said that she was not aware of it. When asked if the decline of the bed cradle recommendation was communicated to the wound physician, she said no. 49880 3. Resident #38 was admitted to the facility in January 2024 with diagnoses that include type 2 diabetes and dysphagia. Review of Resident 38's most recent Minimum Data Set (MDS) assessment, dated 3/27/25, indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating that the Resident has intact cognition. -On 4/15/25 at 7:52 A.M., the surveyor observed the Resident up in his/her wheelchair. The Resident had a dressing on his/her left elbow dated 4/13/25. He/she said they have a wound on their elbow. Review of Resident 38's active physician orders indicated the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Wash wound with wound wash or NS, pat dry, apply skin prep to peri wound (skin surrounding the wound), apply Bacitracin to wound bed and cover with gauze island DSG, every day shift for 30 days dated 4/11/25. [sic] Review of the wound consultant note, dated 4/9/25, indicated that Resident #38 had a skin tear wound of the left elbow, full thickness. Review of Resident 38's active care plan indicated the following: -Resident has a new *skin tear* due to repositioning self in wheelchair, initiated 4/3/25, with interventions that included apply treatment a/o (as ordered) by MD (Medical Doctor). [sic] Review of the April 2025 Treatment Administration Record (TAR) indicated that the dressing was changed to the left elbow on 4/14/25. Review of the Progress notes failed to indicate that the dressing was changed to the left elbow on 4/14/25. Review of Resident #38's most recent weekly skin check assessment, dated 4/14/25, failed to indicate the wound to the left elbow. During an interview on 4/16/25 at 12:38 P.M., Nurse #1 said that she worked on 4/14/25 and took care of Resident #38. She said that she can't remember for sure if she changed the dressing to the left elbow. During an interview on 4/16/25 at 2:08 P.M. the Director of Nurses said that she would expect that nurses would implement physician orders and that if they sign off it is complete, that they have completed the order.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 36431 Based on observation, record review and interview, the facility failed to ensure that for two Residents (#10 and #1) who are unable to carry out activities of daily living, received the necessary services to maintain good grooming, and personal and oral hygiene out of a total sample of 23 Residents. Specifically, 1. For Resident #10, the facility failed to ensure incontinence care was provided timely and in accordance with the standards of care and the Resident care plan. 2. For Resident #1, the facility failed to remove unwanted facial hair. Findings include: Review of the facility policy, titled, ADL (Activities of Daily Living-Personal Hygiene) Last Date Revised 10/2022 included but was not limited to the following: Policy: The purpose of this procedure is to direct the Nursing Staff and meet Residents individual needs per the plan of care and Kardex on a daily basis. Facial hair will be groomed as needed Toileting/incontinence care for a Resident will be provided as needed for each individual Resident per care plan and Kardex. 1. Resident #10 was admitted to the facility in February 2022 and has diagnoses that include but are not limited to unspecified dementia with other behavioral disturbance, type 2 diabetes mellitus, and cerebral infarction. Review of Resident #10's Minimum Data Set (MDS) assessment, dated 3/16/25, indicated the staff assessment for mental status determined severe cognitive impairment for daily decision making, is dependent on staff for toileting hygiene and is always incontinent of bladder and bowel. Further review of the MDS indicated Resident #10 is assessed as high risk for developing pressure ulcers/injuries. Review of the KARDEX (a written summary to guide daily care tasks) dated as of 4/17/2025 indicated: ADL/Personal Hygiene: Max Assist. Bladder/Bowel/Toileting, Toilet Hygiene: Dependent. Review of Resident #10's care plans indicated the following: -A care plan with the focus: Potential alteration in skin integrity: r/t (related to) incontinence of bowel and bladder. Dependence upon staff for care/needs and hx (history) of resolved pressure ulcer R (right) heel, date initiated 2/16/2022, Revision on: 2/23/2025. Interventions included: Protect skin with incontinent care, dated 2/16/2022, Toileting assistance on toileting schedule or routine, dated 2/16/2022. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A care plan focus Self-Care, Resident requires assist with ADLs (activities of daily living) cognitive loss, Generalized weakness increased safety risk, lack of balance, unable to follow simple directions. Would not initiate of follow through d/t (due to) dementia, date initiated 5/7/2024. Interventions included Toilet Hygiene: Dependent. -A care plan focus: Activities of Daily Living Resident will not initiate and unable to follow through with care needs d/t impaired cognition and s/p (status post) stroke, and Dementia (sic), date initiated: 2/16/2022, Revision on 3/8/2025. Goal: Resident will receive assistance with needed in ADL Activities, date initiated: 2/16/2022 revision on 3/22/2025 and target date 6/22/2025. Interventions: Encourage and assist with reposition every 2-3 hours prn (as needed) as resident allows date 2/16/2022. On 4/15/25 at 8:18 A.M., Resident #10 was observed in bed on his/her back. The entrance to the room and area around the room had an odor detected consistent with urine. On 4/15/25 at 8:45 A.M., Resident #10 was resting on his/her back with his/her eyes closed. An odor consistent with urine was detected in and around the room. On 4/15/25 at 9:01 A.M., Resident #10 was set up with his/her breakfast tray and made eye contact but did not respond to the surveyors greeting. Resident #10 continued to have a tray in front of him/her until 9:18 A.M. During an observation and interview on 4/15/25 at 12:24 P.M., Resident #10 was out of bed. An odor was detected consistent with urine was in and around the room/area. Resident #10's bedsheets were observed to be wet. Certified Nursing Assistant (CNA) #2 said the bed was soaked, that she just changed the Resident about 15 minutes ago, that she was assigned to the Resident, and it was the first change since she came in at 7 this morning. CNA #2 said she could not say when the Resident was last changed. During an interview on 4/16/25 at 7:00 A.M., CNA #3 said she worked the 11:00 P.M.-7:00 A.M., shift. CNA #3 said incontinence care is provided about every two hours. CNA #3 said she checks her residents upon coming on her shift, then will do rounds, check to see if changing is required and will change residents. CNA #3 said the last rounds and incontinence care for residents is done between 5:00 A.M and 6:00 A.M. On 4/16/25 the following continuous observations were made: -At 7:02 A.M., Resident #10 was in bed on his/her back. -At 7:36 A.M., Resident # 10 was in bed on his/her back and eyes were closed. -At 7:53 A.M., the MDS (Minimum Data Set) nurse entered Resident #10's room, pulled out blue protective boots and asked the Resident if he/she would let her place them on his/her feet and did so. -At 8:22 A.M., Resident #10 was in bed with the room dark. -At 8:29 A.M., Resident #10 was sitting up in bed, light on and his/her breakfast tray was in front of him/her, and he/she was eating. -At 9:23 A.M., Housekeeping entered Resident #10's room and emptied the trash. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 9:24 A.M., a doctor entered the room and observed both residents. -At 9:38 A.M., CNA #4 entered Resident #10's room, stood at the end of the bed and asked Resident #10 do you want to get up now or later? CNA #4 then exited the room and did not check to see if Resident #10 needed to be changed. -At 10:18 A.M., Resident #10 remained in bed wearing a johnny and did not respond to the surveyors greeting. -At 10:31 A.M., CNA #4 was passing snacks and gave Resident #10 a pudding snack. During an interview on 4/16/25 at 11:03 A.M., four hours into her shift, CNA #4 said she did not yet provide care to Resident #10 today. CNA #4 said when she worked the night shift the last change would be around six in the morning. CNA #4 said Resident #10 is incontinent and needs to be changed every few hours. During an interview on 4/16/25 at 11:07 A.M., Nurse #3 said the Nursing staff supervise the CNA staff and trust they are providing care as a resident requires. Nurse #3 said he was not aware that Resident #10 had not been provided with care until now. Nurse #3 said he would expect the CNAs to round and provide incontinent care by now. Nurse #3 said incontinence care including checking and changing residents should be done every two hours and not more than three hours. Nurse #3 said by not changing timely Resident #10 is at risk for pressure ulcers, urinary tract infection, and dignity. During an interview on 4/16/25 at 2:46 P.M., Unit Manger #1 said she detected an odor of urine on 4/15/2025, from Resident #10's and his/her roommates' room, and was not sure of the source and requested a deep clean. Unit Manager #1 said incontinence care should be provided every two hours and as needed. Unit Manger #1 said the CNA staff should physically check to see if a resident needs to be changed. Unit Manager #1 said she was in Resident #10's room around 6:30 A.M. and said he/she was dry at that time. Unit Manager #1 said not changing Resident #10 until after 11:00 A.M., would increase his/her risk for skin breakdown, and urinary tract infection. During an interview on 4/17/2025 at 8:22 A.M., and 9:42 A.M., the Director of Nursing said she had seen Resident #10 on 4/15/25 to check his/her skin on his/her abdomen and at the time said he/she was not incontinent. The Director of Nursing said the aim is to keep a resident's skin clean, clear and dry, to follow the care plan and optimally change an incontinent resident every two hours. 49880 2. Resident #1 was admitted to the facility in July 2022 with diagnoses that include parkinsonism, dysarthria and chronic pain. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's most recent Minimum Data Set (MDS) assessment, dated 4/3/25, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating that the Resident is cognitively intact. The MDS further indicated that for personal hygiene, defined as the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands, the Resident requires substantial/ maximal assistance. The MDS failed to indicate any behaviors for refusal of care. -On 4/15/25 at 7:47 A.M., the surveyor observed Resident #1 sitting up in his/her wheelchair. He/she said that they have been assisted with getting washed and dressed this morning. There was facial hair present on the Resident's face. -On 4/16/25 at 8:22 A.M., the surveyor observed Resident #1 sitting up in his/her wheelchair eating breakfast. Resident #1 said that he/she has been assisted with washing and dressing this morning. There was facial hair present on the Resident's face. -On 4/16/25 at 1:44 P.M., the surveyor observed Resident #1 sitting up in his/her wheelchair. There was facial hair present on the Resident's face. Review of Resident #1's active care plan for self-care, dated as revised 5/6/24, indicated personal hygiene: max assist. [sic] Resident #1's care plan failed to indicate any refusal of care. During an interview on 4/16/25 at 1:44 P.M., Resident #1 said that it is his/her preference is to have facial hair removed, but no one has offered recently. He/she said that in the past they have shaved it. During an interview on 4/16/25 at 1:52 P.M., Certified Nurse's Aide (CNA) #1 said that if staff notice facial hair on a resident, they should offer to remove it, for both men and women. She said that Resident #1 does sometimes want the facial hair removed and sometimes doesn't but that it should be offered regardless. During an interview on 4/16/25 at 2:12 P.M., the Director of Nurses said that CNA's should be observing for facial hair and removing it as the resident wishes as part of daily activities of daily living care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 36431 Based on observation, record review and interviews, the facility failed to ensure for one Resident (#37), out of a total sample of 23 resident, interventions related to fall, and injury prevention were implemented in accordance with the medical plan of care. Specifically, the facility staff failed to ensure bedside fall mats were in place. Findings include: Review of the policy titled, Fall Preventions and Management, last date revised 1/2023 indicated The Fall Risk Evaluation will determine risk factors. The interdisciplinary team identifies and implements appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence. Resident #37 was admitted to the facility in January 2023 and has diagnoses that include but are not limited to atherosclerotic heart disease, unspecified fracture of right pubis, repeated falls, low back pain and depression. Review of the most recent Minimum Data Set assessment, dated 1/27/25 indicated Resident #37 scored a 10 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having moderately intact cognition, was dependent on staff for toileting and required substantial maximum assistance for bathing. Further review of the MDS indicated Resident #37 had a fall in the last month before admission and the Care Areas Summary for falls was triggered and a care plan would be developed. On 4/15/25 at 8:31 A.M., Resident #37 was observed in bed. A fall mat was on his/her right side of the bed. Review of Resident #37's medical record indicated the following: -A physician's order dated 1/28/2025, floor mats to both sides of bed, every shift. -A care plan focus: Falls: Resident is at risk for fall related injuries related to recent decline in function, recent fall prior to admission with R (right) hip fracture repair, requires staff assistance for mobility dated as initiated 1/23/2025, revision on 4/2/2025. Interventions: Fall mats to both sides of residents (sic) bed. Date initiated: 1/28/25. On 4/16/25 at 7:20 A.M., Resident #37 was observed sitting on the edge of his/her bed on his/her left side of the bed. A fall mat was on his/her right side of the bed. There was no mat on his/her left side of the bed. There was no second fall mat located in the room. At 7:24 A.M., a nurse entered the room and said he would get someone to assist him/her. Resident #37 was sitting close to the edge of the bed and was looking at the doorway. At 7:29 A.M., the Director of Rehabilitation entered and assisted Resident #37 to walk to the bathroom. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/25 at 7:57 A.M., Resident #37 was observed sitting up in a wheelchair next to the left side of his/her bed. A mat is on the floor on the right side of the resident's bed. There was no second fall mat in the vicinity of the room. On 04/16/25 at 3:44 P.M., Resident #37 was observed in his/her bed. A fall mat was on his/her right side. There was no fall mat on his/her left side of the bed and no second mat in the room. On 4/17/25 at 7:34 A.M., Resident #37 was observed in his/her bed with a fall mat on his/her right side. There was no fall mat located on the left side of the bed, as indicated by the fall care plan and physician's order. During an observation and interview on 4/17/25 at 7:32 A.M., Nurse #4 said he worked the 11-7 shift. Nurse #4 said Resident #37 had a history of falls, requires his/her bed to be low. Nurse #4 reviewed Resident #37's physician's orders and said Resident #37 has an order for fall mats on both sides of his/her bed. Nurse #4 went with the surveyor to Resident #37's room and said there was no fall mat on his/her left side and there should be. During an interview on 4/17/25 at 7:42 A.M., Unit Manager #1 said she started as the Unit Manager about two weeks ago. Unit Manager #1 said she knew Resident #37. Unit Manager #1 reviewed Resident #37's medical record and said he/she was assessed to be a high fall risk. Unit Manager #1 said there was an order and a fall care plan to have falls mats on both sides of Resident #37's bed. Unit Manager #1 said all staff are responsible for making sure the mats are present. Unit Manager #1 said the fall mats should be present and in place per the order and care plan. During an interview on 4/17/25 at 8:38 A.M., the Director of Nursing said the fall interventions should be implemented per the order and care plan. Review of an incident report dated 1/28/25 at 00:28 hours (12:28 A.M.) indicated Resident found on floor beside the bed. No obvious injury noted. Resident description try to get to the bathroom as verbalized by patient (sic).

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on observations, record review, and interviews, the facility failed to ensure enteral nutrition provided via a gastrostomy tube (a tube surgically inserted through the abdominal wall directly into the stomach with the purpose of delivering food, typically in the form of liquid formula) was provided according to professional standards for one Resident (#36) out of a total sample of 23 Residents. Specifically, the facility failed to ensure a tube feeding was running according to physician orders for Resident #36. Findings include: Review of the facility policy titled Enteral Feedings, dated and revised January 2022, indicated the following: - Continuous Feeding: Enteral feeding delivered around the clock, Feedings are only stopped for medication administration and routine tube flushes. This type of feeding may or may not use an electronic pump; but typically, a pump is used. -Procedure: 1. Verify physician order 2. Document all assessments, findings and interventions in the medical record. Resident #36 was admitted to the facility in September, 2017 with diagnoses including traumatic brain injury and quadriplegia. Review of Resident #36's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated the Resident was unable to participate in the Brief Interview for Mental Status exam indicating severe cognitive impairment. Further review of the MDS indicated that Resident #36 requires a feeding tube. The surveyor made the following observations: - On 4/16/25 at 6:48 A.M., Resident #36 was awake and laying in bed. Next to the Resident was a pole consisting of a tube feeding pump, tube feeding formula in a gravity bag as well as a water bag. The tube feeding pump was off and the tube feeding formula was not connected to the Resident's abdomen. - On 4/16/25 at 7:44 A.M., 8:31 A.M., 9:11 A.M. and 9:47 A.M., Resident #38 was sleeping in bed. Next to the Resident was a pole consisting of a tube feeding pump, tube feeding formula in a gravity bag as well as a water bag. The tube feeding pump was off and the tube feeding formula was not connected to the Resident's abdomen. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor observed Resident #36 not receiving his/her tube feeding formula for just under three hours. Review of Resident #36's physician's order dated 10/21/24 indicated the following: - Enteral feed every shift Vivonex RTF (a ready-to-feed enteral tube feeding formula) @ 85cc/hr x 24 hours continuous. [sic] Further review of Resident #36's physician's orders failed to indicate an order to hold/stop tube feeding. Review of Resident #36's Nutrition/tube feeding care plan indicated the following intervention revised and dated 10/9/24: - Enteral Nutrition Order: Vivonex via GT (gastric tube) @ 85ml x 24 hours - may be off for care. [sic] During an interview on 4/16/25 at 10:36 A.M., Nurse #1 said Resident #36's tube feeding is continuous, and he/she should always be receiving it. Nurse #1 was not sure why Resident #36's tube feeding was not running in the morning, Nurse #1 said she restarted the tube feeding within the past hour. During an interview on 4/16/25 at 10:55 A.M., the Director of Nursing (DON) said she realized Resident #36 had increased oral secretions, so she wanted to hold the Resident's tube feeding. The DON then said she forgot to transcribe a physician's order to stop the tube feeding and all physician's orders should be followed as written.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339 Based on observations, interviews, and record review, the facility failed to ensure that respiratory care and services consistent with professional standards of practice, were provided for two Residents (#26 and #42), out of a total sample of 23 residents. Specifically, 1. For Resident #26, the facility failed to administer oxygen appropriately and change oxygen tubing as ordered. 2. For Resident #42, the facility failed to ensure continuous oxygen was provided when the Resident left the facility. Findings include: Review of facility policy titled 'Oxygen Therapy', dated 10/2022, indicated the following but not limited to: -The administration of supplemental oxygen is an essential element of appropriate management for a wide range of clinical conditions. However, oxygen should be regarded as a drug and therefore requires prescribing in all but emergency situations. -Failure to administer oxygen appropriately can result in serious harm to the patient. The safe implementation of oxygen therapy with appropriate monitoring is an integral component of healthcare's professional role. -Oxygen is administered according to the physician order. Oxygen is delivered by wall oxygen, oxygen tank (stationary or portable) or concentrator. Method used on the resident need and concentration required and facility capabilities. -Tubing change, oxygen cannula tubing, without humidification are changed weekly and as needed. 1. Resident #26 was admitted to the facility in February 2021 with diagnoses including chronic obstructive pulmonary disorder. Review of Resident #26's Minimum Data Set (MDS) assessment, dated 4/3/25, indicated the Resident scored 14 out of possible 15 on the Brief Interview for Mental Status (BIMS) exam indicating intact cognition. The MDS further indicated that the Resident was on oxygen therapy. On 4/15/25 at 7:55 A.M., the surveyor observed Resident #26 wearing an oxygen nasal cannula, the oxygen tube was lying on the floor not attached to the concentrator and the tubing was undated. On 4/15/25 at 9:06 A.M., the surveyor observed Resident #26 wearing an oxygen nasal cannula, the oxygen tube was lying on the floor not attached to the concentrator and the tubing was undated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/25 at 9:17 A.M., the Surveyor and Nurse #4 observed the Resident's oxygen tubing not connected to the concentrator and the tubing was undated. Nurse #4 said the oxygen tubing should be connected to the concentrator, she said she had been in the room about 25 minutes ago and did not notice the tubing was not connected. She also said the oxygen tubing should be changed weekly and it should have the date and initials of when they were changed and who changed it. Review of the medical record indicated the following: -A physician's order dated 4/13/25 administer oxygen at 3 liter/minute via nasal cannula every shift. -A physician's order dated 10/13/24: Changing oxygen tubing every night shift every Sunday for routine weekly. -Review of the Resident's active respiratory care plan date initiated 5/2/2022 indicated the Resident has diagnosis of chronic respiratory failure and COPD with interventions to Administer oxygen as ordered by provider. During an interview on 4/16/25 at 11:06 A.M., the Director of Nursing said oxygen tubing should be connected to the concentrator and the tubing should be changed weekly and dated to indicate it was changed. 36431 2. Resident #42 was admitted to the facility in August 2023 and has diagnoses that include but are not limited to anxiety disorder and chronic obstructive pulmonary disease. Review the Minimum Data Set assessment dated [DATE] indicated Resident #42 scored a 15 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having intact cognition and requires set-up assistance for daily care. Further review of the MDS indicated Resident #42 uses oxygen. During an interview and observation on 4/15/25 at 7:55 A.M., Resident #42's door to his/her room had a sign that indicated oxygen was in use. Resident #42 was lying on his/her bed. Resident #42 was observed to have a nasal cannula administering oxygen. An oxygen concentrator was next to Resident #42's bed. Resident #42 said he/she was planning to go out today by taxi to go to the store. Resident #42 said he/she does this trip every few weeks. Resident #42 said he/she is not provided with portable oxygen when he/she goes out. Resident #42 said he/she moves slowly and paces him/herself because he/she can get short of breath. Resident #42 said he/she is usually out for a half hour or a little more. Review of Resident #42's physician's orders indicated the following: -May have LOA (leave of absence), order date 8/12/2023. -Oxygen at 2 liters/minute via nasal cannula continuous, every shift, order date 4/24/2024. Review of the leave of absence logbook indicated Resident #42 signed out on 3/21/25 at 6:00 P.M., 3/28/25 at 2:00 P.M., and 4/7/25 at 4:05 [sic]. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #42's medical record indicated the following progress notes: -3/21/25 at 23:02, Type: Nurse note: Alert and oriented x 3, LOA this evening come back at 8pm safely [sic]. Further review of the progress notes after 3/21/25 failed to indicate any further documentation regarding Resident #42's LOAs on the above dates. During an interview on 4/16/25 at 10:35 A.M., Nurse #3 said Resident #42 does go out to the store on occasion. Nurse #3 said he typically works on the 3-11 shift and Resident #42 will usually return during his shift. Nurse #3 was asked by the surveyor if Resident #42 returns using portable oxygen. Nurse #3 said it was a good question and said he could not recall but thinks he/she has it sometimes. Nurse #3 reviewed Resident #42's physician's orders and said the order for oxygen is continuous and that would mean he/she needs it when going out. Nurse #3 said Resident #42 will come out to the desk for something without using oxygen for a short time. Nurse #3 said Resident #42 is alert and oriented and it is a good idea for him/her to have portable oxygen. During an interview and observation on 4/16/25 at 10:48 A.M., Resident #42 said I told you yesterday I do not have portable oxygen in my room. No portable oxygen was observed in Resident #42's room. Resident #42 said he/she decided not to go out yesterday. During an interview on 4/16/25 at 3:49 P.M. Certified Nursing Assistant (CNA) #5 said she knows Resident #42 and will assist the Resident as he/she allows. CNA #5 said Resident #42 will sign out, and that she has not seen him/her use portable oxygen and that she has never provided Resident #42 with portable oxygen. During an interview on 4/16/25 at approximately 4:21 P.M., the facility Receptionist said he has assisted Resident #42 in calling a taxi to go to the store. The receptionist said he has seen Resident #42 go out and come back within an hour. The receptionist said he did not recall if Resident #42 had a nasal cannula or portable oxygen. During an interview on 4/17/25 at 8:01 A.M., Unit Manager #1 said Resident #42 does get anxious, and has behaviors of declining or refusing care. Unit Manager #1 said the order for oxygen is continuous and she was not aware that Resident #42 left for LOA without oxygen. Unit Manager #1 said Resident #42 is alert and oriented. Unit Manager #1 said if the order for oxygen is continuous, it means that when a resident goes anywhere like an appointment or LOA, the resident should have oxygen. Unit Manager #1 said Resident #42 will tell the nursing staff what he/she needs and when he/she is going out. Unit Manager #1 said Resident #42 does not go out a lot but should have portable oxygen. During an interview on 4/17/25 at 8:41 A.M., the Director of Nursing (DON) said if a Resident is on continuous oxygen, it is implied that if they leave the facility, they should have portable oxygen available. The DON said if Resident #42 refused to use the portable oxygen it would be documented in the nurse progress notes.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 49880 Based on observation, record review and interviews, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable mental, and psychosocial well-being for one Resident (#70) out of a total sample of 23 residents. Specifically, the facility failed to ensure recommendations from behavioral health services were relayed to the physician and implemented for Resident #70. Findings Include: Review of facility policy titled Change in Condition, dated as revised 10/2022, indicated the following: -Our facility shall promptly notify the resident, his or her Attending physician, and representative of changes in the resident's medical, mental condition and/or status. Resident #70 was admitted to the facility in May 2024 with diagnoses including major depressive disorder, post traumatic dress disorder and visual hallucinations. Review of Resident 70's most recent Minimum Data Set (MDS) assessment, dated 2/10/24, indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating that the Resident is cognitively intact. The MDS further indicated that the resident received antipsychotic medications. Review of Resident #70's Psychiatric Evaluation and Consultation, dated 1/6/25, indicated the following: -Current Assessment/Plan: Patient seen in follow up on hallucinations and delusions. Patient seen at bedside. Patient reports persistent low mood and auditory/visual hallucinations, which [he/she] described as distressing but not commanding or threatening. Tells me [his/her] room is flooded with water and things appears to be jumping from one spot to another. Tells me [he/she] does occasional hear whispers [sic] -I recommend Abilify (an antipsychotic medication) 2.5 mg (milligrams) daily. Review of progress notes indicated a Physician Note, dated 1/7/25, written by Nurse Practitioner (NP) #1 which indicated the following: -Patient was seen yesterday by Psych NP. Patient did report that is having increased hallucinations. Psych NP discuss with patient to start Abilify 2.5 mg QD (daily) and orthostatic BP (blood pressure) x 1 month weekly. Patient is in agreement with this plan. [sic] -Patient will start Abilify 2.5 mg QD. [sic] Review of active and discontinued physician orders failed to indicate that Abilify was initiated on 1/7/25. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #70's Psychiatric Evaluation and Consultation, dated 1/13/25, indicated the following: -Current Assessment/Plan: Patient is seen at bedside. [He/she] is endorsing ongoing visual hallucination. These symptoms have been going since the last assessment and has not improved. Patient reports [he/she] is experiencing distress related to these hallucinations especially when [he/she] want to pick up something and it turns to something else . Medication adherence is reported as consistent but has not started the Abilify I made recommendation to initiate. I still believe patient can benefit from Abilify for hallucinations and depression. Patient does not appear to be danger to self or others. I recommend to f/u [follow up] with my las rec [recommendation]. [sic] Review of a Progress note written by NP #1, dated 1/14/25, failed to indicate that Resident #70's Abilify recommendation was not started, and failed to address initiating Abilify. Review of the medical record failed to indicate that the Nurse Practitioner or physician were notified of the recommendations made on 1/13/25 to initiate the previously recommended Abilify. Review of Resident #70's psychological Services Supportive Care Progress note, dated 1/21/25 indicated the following: -The goal of this session was to encourage [the resident] to talk about [his/her] feelings, especially [his/her] sense of depression as well as the hallucinations [he/she] was having. Response: [Resident] reported that [he/she] was still seeing items, bugs, or something of that sort on [his/her] bed when the lights were out, and that disappeared when the lights were on. Review of Resident #70's discontinued physician orders indicated the following: -Abilify 2.5 mg by mouth daily for visual hallucinations, administered 1/29/25 through 2/13/25. -Abilify 5 mg by mouth daily for visual hallucinations, administered 2/14/25 through 2/21/25. Review of the medical record, including the January 2025 Medication Administration Record indicated that Abilify was not initiated until 1/29/25, 23 days after it was initially recommended for the treatment of visual and auditory hallucinations that were distressing to the Resident. Review of Resident #70's Psychiatric Evaluation and Consultation, dated 2/13/25 indicated the following: -I recommend to d/c [discontinue] Abilify 2.5 mg start Abilify 5 mg daily. [sic] During an interview on 4/16/25 at 12:38 P.M., Nurse #1 said that when recommendations are made by consultants such as psych services, the nurses let the NP know, she reviews the recommendations and approves it. She said that sometimes the NP enters the orders directly into the Electronic Medical Record (EMR) and sometimes the nurses enter them. She said most of the time the NP approves the orders and nursing is responsible for ensuring they are entered in the EMR. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/16/25 at 12:51 P.M., Nurse Practitioner #1 said that regarding psych recommendations she typically has a conversation with the psych NP about the recommendations. A copy of the recommendation is provided also to the Director of Nurses. NP #1 said that sometimes she will enter the orders into the EMR, but it is the expectation that nursing enters them or ensures that they are entered. She said that she was aware of the initial recommendation for Resident #70 to start taking Abilify for hallucinations, but was never made aware after the 1/13/25 psych visit that the Abilify was never initiated. She was under the impression that the Resident had been taking it since 1/7/25. She said that if she was notified of the recommendations on the 1/13/25 psych visit note then she would have told nursing staff to initiate the Abilify as recommended. She said she would have expected to be notified of the second recommendation, but she was not. During an interview on 4/16/25 at 2:15 P.M., the Director of Nurses said that since her arrival at the facility two weeks ago, the process is that the psych NP gives their recommendations to the Nursing Supervisor, the NP as well as the Director of Nurses. She said that the nursing supervisor enters the recommendations and that she double checks to make sure they are accurate. She said that when the recommendation and notification that Abilify was not started came through on 1/13/25 someone should have notified the NP or physician that it had not been initiated, but it did not appear that they did.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36431 Based on observation, record review and interviews, the facility failed to ensure food is stored, prepared and distributed in accordance with professional standards in food safety and sanitation to prevent the spread of pathogens, which could result in foodborne illness for the residents. Specifically, 1. food stored in the dry storage area, and walk-in refrigerator were not labeled and dated, and 2. Staff failed to ensure safe food handling during the lunch meal distribution. Findings include: Review of the facility policy titled, Food Storage, not dated indicated Food should be stored and prepared in a clean safe sanitary manner that complies with state and federal guidelines. Purpose: to minimize contamination and bacteria. Review of the facility policy titled, Handling, Serving, and Transporting Foods, not dated indicated: Foods should be handled, served and transported at the proper holding temperatures. Food should be presented attractively, under sanitary conditions, and according to the facility menu. Purpose: to prepare, present, and serve plates safely and attractively. Procedure: 1. Use properly cleaned and sanitized utensils, 2. Use proper utensils according to the menu and standardized recipe. 3. There must be a separate utensil for every item on the tray line. 4. Practice good personal hygiene. 1. During the observation of the kitchen on 4/15/25 at 7:07 A.M., the following was observed: - Dry storage: a large bag of rice was left open, not secure, and was not dated. [NAME] #2 said all items are to be secure and dated when opened. - Walk-in refrigerator: a tray with multiple single serving bowls containing green salad were not dated. The Food Service Director (FSD) said salad is served daily and should be labeled and dated. 2. During observation of the lunch meal distribution tray line on 4/16/25 starting at 11:35 A.M., the surveyor made the following observations: Cook #1 dropped a plate and got a cut on her hand which had a small amount of blood present. [NAME] #1 stopped plating, went and got a Band-Aid, covered the cut and proceeded to put on gloves, when the Food Service Director intervened and asked [NAME] #1 to wash her hands before placing on the gloves. After [NAME] #1 performed hand hygiene and donned gloves on both hands the following was observed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cook #1 reached into a plastic bag containing hot dog buns and removed the hot dog buns with her gloved hands and plated them on individual plates multiple times. [NAME] #1 did not use utensils to plate the buns. With the same gloved hands [NAME] #1 touched the steam oven door handles and removed a grilled cheese sandwich, then with contaminated gloves continued to reach in the hot dog bun package and removed and plated the buns on multiple individual plates. [NAME] #1 was handed by a dietary aid a dietary paper slip, which she touched with her gloved hands, read it then returned it to the dietary aid. [NAME] #1 between food trucks leaned her gloved hands on the shelf in front and then rested her gloved hands on her back, directly in contact with her clothing. [NAME] #1 resumed plating hot dog buns directly with her contaminated gloved hands. [NAME] #1 touched the utensils for other food including the ladle for macaroni salad. [NAME] #1 touched and removed a hot dog bun with ground hot dog from one plate on to another plate. [NAME] #1 picked up the empty hot dog bun bags, walked from the tray line and threw them into an open trash container, then returned to the tray line. [NAME] #1 with the same gloved hands, touched both handles of the oven and removed a grilled cheese sandwich, removed the foil and plated it directly. [NAME] #1 then left the tray line area and went to the bakery rack and removed a hamburger bun package with the same gloved hands. [NAME] #1 opened the plastic bag of hamburger buns removed the bun, then touched a stack of cheese slices, removed a cheese slice placed it on a hamburger and put it in the streamer. Cook #1 then returned to plating, then returned to the steamer and removed the hamburger bun and placed it directly on a plate. [NAME] #1 continued to touch the sliced cheese, hamburger bun, steam oven door with the same gloved hands a few times during the observation. After touching the ladle for the macaroni salad, the ladle fell into the pan and the handle of the ladle was in direct contact with the macaroni salad. [NAME] #1 continued to remove hot dog buns with her gloved hands and placing them on individual plates. [NAME] #1 removed the ladle from the macaroni salad and used the contaminated ladle to plate the macaroni salad multiple times. At 12:03 P.M., [NAME] #1 removed her gloves, performed hand washing then donned new gloves and proceeded to touch hot dog buns directly to plate. Then [NAME] #1 touched the oven door, removed a grilled cheese, then proceeded to touch the grill cheese directly and resumed to touch hot dog buns directly. The observation ended at 12:13 P.M. During an interview on 4/16/25 at 1:43 P.M., the FSD said [NAME] #1 left and was not available for an interview. The FSD said all utensils were clean before the tray line and that [NAME] #1 should not have touched the food items directly. The FSD said [NAME] #1 should not have touched food directly after touching her clothing, surfaces and the oven doors. The FSD said the dietary tray ticket is handled multiple times by staff and should not have been touched by the Cook. The FSD said the handle of the ladle used for the macaroni salad should not have been in contact with the food. The FSD said the observations made were not what was expected for proper food handling.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339 Based on record review and interviews, the facility failed to ensure a current hospice care plan was present in the medical record and coordinated with facility staff for one Resident (#71) out of a total sample of 23 residents. Findings include: Review of the facility policy titled 'Hospice Services', last revised January 2023, indicated the following but not limited to: -When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms. -The hospice agency retains overall professional management responsibility for directing the implementation of the plan of care related to the terminal illness and related conditions, which include: -The facility and hospice will identify the specific services that will be provided by each entity, and this information will be communicated in the plan of care. Based on record review and interviews, the facility failed to ensure a current hospice care plan was present in the medical record and coordinated with facility staff for one Resident (#71) out of a total sample of 23 residents. Findings include: Review of the facility policy titled 'Hospice Services', last revised January 2023, indicated the following but not limited to: -When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms. -The hospice agency retains overall professional management responsibility for directing the implementation of the plan of care related to the terminal illness and related conditions, which include: -The facility and hospice will identify the specific services that will be provided by each entity, and this information will be communicated in the plan of care. Resident #71 was admitted to the facility in June 2024 with diagnoses including pressure ulcer of sacral region stage 4. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225644	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Rehab Center	7 Loring Hills Avenue Salem, MA 01970

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #71's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident scored a 10 out of possible 15 on the Brief Interview for Mental Status, indicating he/she had moderate cognitive impairment. The MDS further indicated that the Resident was receiving hospice services. Review of Resident #71's medical record indicated the following: -A physician's order dated 3/20/25, admit to [contracted] hospice services. -A facility care plan: I am receiving hospice services for end-of-life care, dated 3/20/25. Review of the medical record failed to indicate the hospice agency's plan of care was available to the staff at the facility. During an interview on 4/16/25 at 10:15 A.M., Nurse #2 said all hospice communication for Resident #71 was uploaded in the electronic medical record. During an interview on 4/16/25 at 2:04 P.M., the Director of Nursing said hospice had not sent over the plan of care and that the plan of care should be available for staff to review.